United States Department of Labor
Employees' Compensation Appeals Board

T.T., Appellant	)	
and	)	**Docket No. 09-1379**
	)	**Issued: March 10, 2010**
DEPARTMENT OF HOMELAND SECURITY, FEDERAL AIR MARSHALL SERVICE, Coraopolis, PA, Employer	)	

Appearances:
Jeffrey P. Zeelander, Esq., for the appellant
Office of Solicitor, for the Director

Case Submitted on the Record

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
MICHAEL E. GROOM, Alternate Judge

JURISDICTION

On May 5, 2009 appellant, through his attorney, filed a timely appeal from an April 22, 2009 merit decision of the Office of Workers' Compensation Programs regarding a schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of the case.

ISSUE

The issue is whether appellant established that he has more than a four percent permanent impairment of his lower extremity, for which he received a schedule award.

On appeal, appellant's representative contends that, when there is more than one method of evaluating impairment, the method yielding the highest rating is appropriate. As Dr. Michael J. Platto, Board-certified in physical medicine and rehabilitation, determined that appellant sustained either 20 percent or 10 percent lower extremity impairment, the correct impairment rating should have been 20 percent.

FACTUAL HISTORY

On September 8, 2006 appellant, then a 47-year-old civil aviation security specialist and instructor, filed a traumatic injury claim (Form CA-1) alleging that he sustained a left knee injury on August 21, 2006 while running during a certification course at the employing establishment's training facility. He claimed that his left knee buckled during a one and a half mile run and that he experienced severe pain and tightness. The Office accepted the claim for left knee medial meniscus tear.

On November 28, 2006 appellant underwent a left knee arthroscopy and partial medial meniscectomy. On December 11, 2007 he underwent a diagnostic left knee arthroscopy, revision of partial medial meniscectomy, partial synovectomy and chondroplasty of Grade 4 osteochondral lesion of the medial femoral condyles.

On March 16, 2009 appellant filed a claim for a schedule award (Form CA-7).

In a February 24, 2009 medical report, Dr. Platto discussed appellant's occupational and medical history. Physical examination revealed thigh measurements, 10 centimeters above the lateral joint line, of 46 centimeters on the right and 47 centimeters on the left. Range of motion of the left knee showed flexion of 122 degrees and extension lacking 2 degrees. Appellant had full range of motion of the right knee, no tenderness to palpation and no swelling, erythema or warmth around the left knee. Dr. Platto noted that appellant did have a slight varus deformity of the left knee at five degrees but no varus or valgus of the right knee. He diagnosed left knee pain, status post partial medial meniscectomy on November 28, 2006 and revision of partial medial meniscectomy with excision of loose bodies and partial synovectomy on December 11, 2007. Dr. Platto opined that, in accordance with Table 17-10 on page 537 of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (5th ed. 2001) (A.M.A., *Guides*), a 5 degree varus deformity of the knee would convert to 8 percent whole person or 20 percent lower extremity impairment. Alternatively, according to Table 17-33 on page 546, a diagnosis-based rating for a partial meniscectomy would convert to 4 percent whole person or 10 percent lower extremity impairment. Dr. Platto noted that the range of motion impairment, based on the varus deformity, would give a higher rating. However, he opined that the diagnosis-based impairment rating of four percent was the most clinically accurate representation of appellant's overall function as he was able to walk normally, squat down and get up. Appellant also demonstrated a full range of motion and did not appear to experience pain with palpation around the left knee. Dr. Platto concluded that the diagnosis-based rating was most accurate and that appellant sustained four percent whole person impairment from his left knee injury.[1]

On April 7, 2009 the Office forwarded Dr. Platto's medical report to Dr. Arnold T. Berman, a Board-certified orthopedic surgeon and Office medical adviser, for an impairment rating in accordance with the A.M.A., *Guides*.

[1] Dr. Platto also provided impairment ratings for appellant's right and left shoulder. As appellant's claim was only accepted for a left knee injury, impairments to his shoulders are not at issue in this appeal.

In an April 18, 2008 medical report, Dr. Berman agreed with Dr. Platto that there were two different methodologies for calculating appellant's impairment: the diagnostic-based method for a medial meniscectomy and range of motion method for a varus deformity. He stated that diagnosis-based estimates and range of motion ratings, which included the charts involving varus and valgus deformities, cannot be combined according Table 17-2 on page 527 of the A.M.A., *Guides*. Dr. Berman recommended that the diagnosis-based estimate be used to calculate impairment due to Dr. Platto's opinion that this was the most accurate representation of appellant's overall functioning. He noted Dr. Platto's finding that appellant was able to walk normally, squat, demonstrate a full range of motion of the left knee and did not have pain with palpation around the left knee. Dr. Berman found that, according to Table 17-33 on page 546, an impairment rating for a partial medial meniscectomy equates to 2 percent impairment or 4 percent if done twice. He concluded that appellant sustained four percent permanent impairment of the left lower extremity. Dr. Berman noted a maximum medical improvement date of January 23, 2009, the date of Dr. Platto's examination.

By decision dated April 22, 2009, the Office granted appellant a schedule award for four percent impairment of the left lower extremity for two medial meniscectomies according to Table 17-33 on page 546 of the A.M.A., *Guides*. It noted a maximum medical improvement date of January 23, 2009.

LEGAL PRECEDENT

Section 8107 of the Federal Employees' Compensation Act[2] sets forth the number of weeks of compensation to be paid for the permanent loss of use of specified members, functions and organs of the body.[3] The Act, however, does not specify the manner by which the percentage loss of a member, function or organ shall be determined. To ensure consistent results and equal justice for all claimants under the law, good administrative practice requires the use of uniform standards applicable to all claimants.[4] The A.M.A., *Guides* has been adopted by the implementing regulations as the appropriate standard for evaluating schedule losses.[5]

The A.M.A., *Guides* provides three separate methods for calculating the impairment of an individual: anatomic; functional and diagnosis based.[6] The anatomic method involves noting changes, including muscle atrophy, nerve impairment and vascular derangement, as found during physical examination.[7] The diagnosis-based method may be used to evaluate impairments caused by specific fractures and deformities, as well as ligamentous instability, bursitis and various surgical procedures, including joint replacements and meniscectomies.[8] The functional

[2] 5 U.S.C. §§ 8101-8193.

[3] *Id.* at § 8107.

[4] *Ausbon N. Johnson*, 50 ECAB 304, 311 (1999).

[5] 20 C.F.R. § 10.404.

[6] A.M.A., *Guides* 525.

[7] *Id*.

[8] *Id*.

method is used for conditions when anatomic changes are difficult to categorize or when functional implications have been documented and includes range of motion, gait derangement and muscle strength.[9] The evaluating physician must determine which method best describes the impairment of a specific individual based on patient history and physical examination.[10] When uncertain about which method to use, the evaluator should calculate the impairment using different alternatives and choose the method or combination of methods that gives the most clinically accurate impairment rating.[11] If more than one method can be used, the method that provides the higher impairment rating should be adopted.[12]

ANALYSIS

The Office accepted that appellant sustained a torn medial meniscus of the left knee. The issue is whether he sustained greater than four percent permanent impairment to his lower extremity due to this injury.

In a February 24, 2009 medical report, Dr. Platto, appellant's treating physician, diagnosed left knee pain, status post partial medial meniscectomy on November 28, 2006 and revision of partial medial meniscectomy on December 11, 2007. Physical examination revealed a slight varus deformity of the left knee at five degrees.[13] Dr. Platto found that the diagnosis-based method was a more clinically accurate representation of appellant's overall function than the range of motion method as he was able to walk normally, squat down and get up. Appellant also demonstrated a full range of motion of the left knee and did not have pain with palpation around the left knee. Using Table 17-33 on page 546, Dr. Platto stated that appellant sustained 4 percent whole person impairment, the equivalent of a 10 percent lower extremity impairment.[14]

The Board finds that Dr. Platto did not properly apply the A.M.A., *Guides*. In applying Table 17-33, Dr. Platto inverted the ratings provided for whole person and lower extremity impairment.[15] Moreover, it appears as though he incorrectly used the four percent impairment rating for a partial medial and lateral meniscectomy, instead of the two percent rating for a

[9] *Id.* at 525, Table 17-1.

[10] *Id.* at 548, 555.

[11] *Id.* at 526.

[12] *Id.* at 527, 555.

[13] The A.M.A., *Guides* includes the impairment ratings for varus and valgus deformities in Chapter 17.2f for calculating range of motion impairments. Thus, these deformities are rated through the range of motion method. *Id.* at 537.

[14] *Id.* at 546.

[15] Although the A.M.A., *Guides* provides impairment figures for the whole person, the Act does not authorize the payment of schedule awards for the permanent impairment of the whole person. Payment is authorized only for the permanent impairment of specified members, organs or functions of the body. *See Ernest P. Govednick*, 27 ECAB 77 (1975).

partial medial meniscectomy. As Dr. Platto did not provide an impairment rating in accordance with the A.M.A., *Guides*, his rating is of reduced probative value.[16]

The Office properly referred Dr. Platto's medical report to Dr. Berman, an Office medical adviser, for an impairment rating in accordance with the A.M.A., *Guides*. In an April 18, 2008 report, Dr. Berman found that appellant's impairment could be rated with either the diagnostic-based method or the functional method using range of motion based on a varus deformity. He noted that these methods could not be combined in accordance with Table 17-2 on page 527 of the A.M.A., *Guides*.[17] Dr. Berman recommended that the diagnosis-based method be used to calculate appellant's impairment based on Dr. Platto's opinion that this was the most accurate representation of appellant's overall function. He noted Dr. Platto's findings that appellant was able to walk normally, squat, demonstrate a full range of motion of the left knee and did not have pain with palpation around the left knee.[18] Dr. Berman stated that Table 17-33 on page 546 of the A.M.A., *Guides* provided two percent impairment rating for a partial medial meniscectomy.[19] As appellant underwent two partial medial meniscectomies, he sustained four percent permanent impairment to the lower extremity.

It is well established that, when the treating physician fails to provide an estimate of impairment conforming to the A.M.A., *Guides*, his opinion is of diminished probative value in establishing the degree of any permanent impairment. The Office may then rely on the opinion of its medical adviser to apply the A.M.A., *Guides* to the findings reported by the treating physician.[20] The Board finds that Dr. Berman correctly applied the A.M.A., *Guides* to Dr. Platto's findings in concluding that appellant sustained four percent impairment of his lower extremity. The Office properly relied on his opinion in granting appellant a schedule award for four percent impairment of her lower extremities.

On appeal, appellant's representative contends that appellant is entitled to a schedule award for 20 percent impairment of the lower extremity, as this was the highest impairment rating by Dr. Platto. In accordance with the A.M.A., *Guides*, the highest impairment rating is to be used where, in a given instance, there are two methods of rating an injury that both produce clinically accurate impairment ratings.[21] This is not the situation in this case. As noted, both Drs. Platto and Berman determined that the diagnosis-based method provided a more accurate rating due to appellant's overall functional capabilities than the functional method. They provided a reasoned explanation for finding that the diagnosis-based method was the most

[16] *See J.Q.*, 59 ECAB___ (Docket No. 06-2152, issued March 5, 2008).

[17] A.M.A., *Guides* 527.

[18] During the physical examination, Dr. Platto also noted one centimeter left thigh atrophy. According to Table 17-2 on page 526 of the A.M.A., *Guides*, muscle atrophy cannot be combined with the diagnosis-based method of determining impairment. Thus, appellant's muscle atrophy was properly excluded from the impairment rating. *Id.* at 526.

[19] *Id.* at 546.

[20] *Linda Beale*, 57 ECAB 429 (2006).

[21] A.M.A., *Guides* 527, 555.

clinically accurate rating method in appellant's case. As such, appellant's impairment rating was properly based on this method.[22] The Board finds that the Office properly awarded appellant a schedule award for four percent permanent impairment of the lower extremity.

CONCLUSION

The Board finds that appellant did not establish that he has more than a four percent permanent impairment to his lower extremity, for which he received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the April 22, 2009 decision of the Office of Workers' Compensation Programs is affirmed.

Issued: March 10, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

Michael E. Groom, Alternate Judge
Employees' Compensation Appeals Board

[22] *See James R. Hill*, 57 ECAB 583 (2006).